Epitomes
Important Advances in Clinical Medicine

Obstetrics and Gynecology

The Scientific Board of the California Medical Association presents the following inventory of items of progress in obstetrics and gynecology. Each item, in the judgment of a panel of knowledgeable physicians, has recently become reasonably firmly established, both as to scientific fact and important clinical significance. The items are presented in simple epitome and an authoritative reference, both to the item itself and to the subject as a whole, is generally given for those who may be unfamiliar with a particular item. The purpose is to assist busy practitioners, students, research workers, or scholars to stay abreast of these items of progress in obstetrics and gynecology that have recently achieved a substantial degree of authoritative acceptance, whether in their own field of special interest or another.

The items of progress listed below were selected by the Advisory Panel to the Section on Obstetrics and Gynecology of the California Medical Association and the summaries were prepared under its direction.

Reprint requests to Division of Scientific and Educational Activities,
California Medical Association, PO Box 7690, San Francisco, CA 94120-7690

AIDS and Pregnancy

MORE THAN 50,000 clinical cases of the acquired immunodeficiency syndrome (AIDS) have been reported in the United States as of January 1988. It is now estimated that more than 2 million Americans have serologic evidence of human immunodeficiency virus (HIV) infection. The Centers for Disease Control (CDC) define the following groups of women to be at high risk for HIV infection: intravenous drug abusers, prostitutes, partners of men with HIV infection, immigrants from certain endemic areas—Haiti and Central or Eastern Africa—or partners of men from these areas, and those who received blood or certain blood products before 1985. Although women currently constitute only 10% of all AIDS cases and most of these belong to one of the defined high risk groups, the number of seropositive women may increase dramatically in the near future as heterosexual intercourse becomes a more common mode of transmission. The incidence of HIV seropositivity in pregnancy may also rise because many of these women will be in the reproductive age group.

All seropositive women should be counseled about the implications of HIV infection for themselves and their progeny. The best estimates currently suggest a 50% risk of transmitting the virus from an infected woman to her fetus. Infants with HIV infection generally become ill within the first one to two years of life and can be expected to die within two years of the onset of symptoms. Pregnant seropositive women are also at increased risk for premature labor, premature rupture of the membranes, and intrauterine growth retardation. Cesarean section does not protect a fetus from HIV infection as it does from herpesvirus infection. Breastfeeding is contraindicated because the virus has been documented in human breast milk. There are considerable risks of maternal HIV infection for the fetus. There is some disagreement as to whether pregnancy and its associated alterations in the immune system accelerate the progression of HIV disease.

Anticipating a growing number of HIV seropositive women, the CDC has recently issued recommendations for preventing HIV transmission in the course of providing health care to these women. All patients should be considered potentially infected, and appropriate precautions in handling blood, blood products, and secretions should be practiced routinely. Gloves, masks, gowns, and protective eyewear are suggested for all invasive procedures and for cesarean and vaginal deliveries. Gloves and gowns should be worn when handling the umbilical cord, placenta, or a newborn when amniotic fluid or blood is present.

MICHAEL VARNER, MD
Salt Lake City
R. JANE LAU, MD
Evansville, Indiana

REFERENCES

Minkoff H, Nanda D, Menez R, et al: Pregnancies resulting in infants with acquired immunodeficiency syndrome or AIDS-related complex: Follow-up of mothers, children, and subsequently born siblings. Obstet Gynecol 1987 Mar; 69:288-291

Committee on Obstetrics: Maternal and Fetal Medicine, Committee on Gynecologic Practice: Prevention of Human Immune Deficiency Virus Infection and Acquired Immune Deficiency Syndrome (Committee Statement). The American College of Obstetricians and Gynecologists, 1987 Jun

Recommendations for prevention of HIV transmission in health-care settings. MMWR 1987; 36 August suppl:2S

Diagnosing Breast Disease

DIAGNOSING BREAST DISEASE is based on physical examination, imaging techniques, and biopsy.

A patient, following an instruction manual, should routinely examine her breasts about one week to ten days after menses. Examination by a physician should be on at least a yearly basis with appropriate follow-up and management of suggestive lesions, especially for patients with high risk factors.

The American Cancer Society recommends a screening baseline mammogram at age 35, then a mammogram every other year from age 40 to 50, and yearly mammograms beginning at age 50. Women having screening mammograms have a reduced mortality rate from breast cancer compared with controls. Screening mammography may indicate patients requiring biopsy by revealing architectural distortion or microcalcification. This technique may also reveal a breast tissue type at a higher risk for carcinoma, indicating yearly mammographic surveillance, even if the patient is younger than 50 years.

In cases of suggestive masses, mammography may be indicated before an open biopsy is done. The presence of calcification in a mass is used to confirm removing the questionable area by a postbiopsy mammogram that reveals remaining calcification in the specimen. Also, subclinical